Minutes of the meeting of the Managed Care Committee of the Board of Directors of the Cook County Health and Hospitals System held Thursday, January 22, 2015 at the hour of 10:00 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Lerner called the meeting to order.

Present: Chairman Wayne M. Lerner, DPH, LFACHE and Director Emilie N. Junge (2)

Board Chairman M. Hill Hammock (ex-officio) and Director Ada Mary Gugenheim

Absent: Director Carmen Velasquez (1)

Additional attendees and/or presenters were:

Krishna Das, MD – System Chief Quality Officer
Doug Elwell – Deputy CEO of Strategy and Finance
Steven Glass – Executive Director of Managed Care
Randolph Johnston – System Associate General Counsel
Elizabeth Reidy – General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD –Chief Executive Officer

II. Public Speakers

Chairman Lerner asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Opening Remarks

In his opening remarks, Chairman Lerner noted that, while the CountyCare operation will clearly have a financial side to it as well as a quality side to it, this Committee has chosen to not take that on as part of its responsibility as an initial focus; rather, the Managed Care Committee is going to work with management to talk about those interventions/actions/management prerogatives that help to manage a risk-based population. Towards that end, the Committee is going to have many more discussions about what that means. It will address questions such as: what is and is not directly under its control; what factors are societally-based, versus institutionally-based; and how the System can work better to serve its patients and families by working together to help manage their health status and their functional status. He stated that this is a work in progress; it will change over time, but the focus will really be - given its population and its size, and where we want to go with our population, how do we help them manage their health? There are all kinds of techniques and processes that other health care organizations have implemented; the Committee will look at those to see if they are valid for the CountyCare Health Plan, and will bring in some outside perspectives as it does that.

Dr. John Jay Shannon, Chief Executive Officer, provided additional comments. He stated that the organization is early in its own journey of actually living in a managed care environment. Besides the development of the ownership and operation of an insurance product itself, the organization's maturity and understanding of how to interact in a managed care environment and how the organization effectively interacts with its members, with a large panoply of different kinds of plans in a dynamic environment, is a big part of what the Committee will be discussing.

IV. Overview

Doug Elwell, Deputy Chief Executive Officer of Finance and Strategy, provided an overview and introduction to the subject. He stated that there will be a lot of innovations employed in this area that will not be seen from other managed care plans; one example is an initiative regarding housing. Housing is a key determinant for those with behavioral health issues; if they have stable housing, they do better, and they are a better financial risk. Additionally, he noted that they working to address housing needs for a small number of people who have sickle-cell disease and who are homeless, because that is a disease that is very much affected by stress; higher stress means higher costs. Another initiative planned is related to the concept of food as medicine and what that means; the administration expects to start a pilot program to determine whether people's medical situations, ability to function and cost of their care can be addressed by looking at food as medicine.

Board Chairman Hammock noted that this will also have significant impact on how the administration focuses its staff resources – there will be much more activities that take place outside of the hospital setting, and that will require adjustments from top to bottom on how staff are employed. Mr. Elwell concurred; he stated that, in some cases, it will require re-training of some employees to do something different, in others, it will require a whole new skill set.

V. Report on CountyCare Health Plan (Attachment #1)

Steven Glass, Executive Director of Managed Care, provided an overview of the Report on the CountyCare Health Plan. The Committee reviewed and discussed the information.

Mr. Glass noted that, with regard to membership, in the month of January, another 11,000 members were added to the ranks; most of the increase is due to auto-assignments of Family Health Plan members. He added that, on February 1st, data is reflecting that membership will be increased by an additional 31,000 members. The Committee discussed the subjects of the redetermination process and auto-assignments; Chairman Lerner noted that it would be helpful to receive some education on those topics at a future meeting[1].

With regard to the information contained in slide 4 of the presentation, Board Chairman Hammock requested further clarification on the data; in the column containing the FY'15 Budget data, it appeared that the sum of the categories did not add up to the total monthly membership figure. Mr. Glass concurred; he stated that he will revise to reflect the correct numbers. Chairman Lerner stated that it would be helpful to not only to look at trending of actuals, but to also trend against the budget[2].

On slide 7, regarding risk management metrics, Chairman Lerner requested that a key be provided to reflect the designation of the colors of red, yellow and green for that data[3].

The Committee discussed the subject of primary care medical home assignment. Mr. Glass stated that Medicaid beneficiaries have the right to switch their primary care provider once in every calendar month. With the choice process, members are locked into their health plan, but once they are in a plan, they can switch their primary care providers once every 30 calendar days. He indicated that he will investigate further to see if this is a metric that can be pulled, to see how many members switch on a regular basis.

Board Chairman Hammock referenced a recent article regarding hospitals that are penalized primarily by Medicare for readmissions. Mr. Glass clarified that the number referenced in this data (21%) represents readmissions of CountyCare Health Plan members; he stated that they have not yet broken out whether there is a higher percentage of readmissions at certain hospitals versus others. Additionally, he noted that he has requested detail on the percentage of readmissions for the same diagnosis.

V. Report on CountyCare Health Plan (continued)

Board Chairman Hammock noted that, as Chairman Lerner mentioned, this Committee is not expecting to cover aspects relating to finance and quality that are covered by other Standing Committees. However, he asked that this Committee work closely with the Finance and Quality and Patient Safety Committees so that metrics for the other two Committees could be overlaid on Managed Care, and are not lost in a larger set of hospital or other metrics.

Director Junge inquired regarding the post-corrections population; she asked whether staff can ask the applicant whether their children are eligible during the application process. Mr. Glass responded that, as staff works with the adult around their access to benefits, he is unsure as to what extent they are screening; he indicated that he will research that question further.

VI. Adjourn

Director Junge, seconded by Chairman Lerner, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY and the meeting adjourned.

Respectfully submitted,
Managed Care Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXX
Wayne M. Lerner, DPH, LFACHE, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

[1] Follow-up: request to receive education on the redetermination process and auto-assignments at a future meeting. Page 2.

[2] Follow-up: request to not only to look at trending of actuals, but to also trend against the budget. Page 2.

[3] Follow-up: regarding risk management metrics, request that a key be provided to reflect the designation of the colors of red, yellow and green for that data. Page 2.

Follow-up: research further – outstanding questions: 1) availability of data on members who switch primary care providers; 2) whether there is a higher percentage of readmissions at certain hospitals versus others within the CountyCare network; 3) availability of data on readmissions for same diagnosis; and 4) post-corrections population –regarding screening process and ability to inquire/determine if applicant has children who may be eligible.

ATTACHMENT #1

CountyCare
HEALTH PLAN

CountyCare Report

Prepared for: CCHHS Board Managed Care Committee

STEVEN GLASS, EXECUTIVE DIRECTOR, MANAGED CARE

JANUARY 22, 2015

Health Plan Reporting

In scope…

- Managing risk
- Social determinants of health
- Population/public health perspective

Not in scope…

- Financial, clinical and compliance

Report Format

1. Membership
2. Risk Management
3. Care Management
4. Operations
5. Future initiatives

Inclusive of metrics throughout

Membership

Data as of: 1/6/2015 | Source: Daily Membership (834) File

	Oct'14	Nov'14	Dec'14	Change From Nov'14	Trend	FY'15 Budget	% to Budget
Monthly Membership	88,894	85,085	86,470	1.6%	↑	92,886	93.1%
ACA	*88,348*	*82,496*	*79,124*	-4.1%	↓	*92,136*	*85.9%*
FHP	*353*	*1,324*	*6,998*	428.5%	↑	*15,000*	*46.7%*
SPD	*113*	*1,038*	*1,371*	32.1%	↑	*3,514*	*39.0%*
Home/Community Waiver	*80*	*227*	*271*	19.4%	↑		

Gender = 50% Female; 50% Male

Average age = Female: 41 y/o; Male: 39 y/o

FHP membership below budget due to State implementation delay

- Expected to catch-up in later months

ACA redeterminations suspended in December

- Member loss due to other eligibility factors

Health Plan Enrollment

Source: HFS

ACA/FHP Enrollment		
Health Plan	**Nov'14**	**Dec'14**
Family Health Network	107,840	151,195
Harmony Health Plan	111,300	123,966
CountyCare	**85,453**	**83,733**
Blue Cross Blue Shield	9,875	43,575
Advocate Accountable Care (ACE)	14,195	34,495
Meridian Health Plan	13,812	33,848
IlliniCare Health Plan	10,520	31,944
Aetna Better Health Inc.	7,977	22,848
SmartPlan Choice (ACE)	2,160	17,661
HealthCura (ACE)	302	14,318
Community Care Partners (ACE)	2,007	9,700
Illinois Partnership for Health (ACE)	1,598	3,731
Loyola Family Care (ACE)	1,665	3,390
MyCare Chicago (ACE)	414	1,937
UI Health Plus (ACE)	155	976
Better Health Network (ACE)	263	801
Next Level (CCE serving ACA only)	34	609
Lurie Children's Health Partners (CSN CCE)	181	434
LaRabida Coordinated Care Network (CSN CCE)	39	92
Total	**369,790**	**579,253**

Integrated Care Program Enrollment		
Health Plan	**Nov'14**	**Dec'14**
Aetna Better Health Inc.	29,377	29,180
IlliniCare Health Plan Inc.	28,422	28,067
Community Care Alliance of Illinois	7,726	7,766
Blue Cross/Blue Shield of Illinois	5,422	5,597
Humana Health Plan	4,616	4,603
Cigna HealthSpring of Illinois	4,162	4,142
Meridian Health Plan	4,143	4,188
Next Level (CCE)	4,059	3,826
EntireCare (CCE)	2,211	2,179
Together4Health (CCE)	1,530	1,582
Be Well (CCE)	1396	1,374
CountyCare	**1,169**	**1,535**
Total	**94,233**	**94,039**

Risk Management

Actions taken to minimize financial risk assumed by health plan

May include structural arrangements

Current Activities	Dashboard Metrics
ACA Adult Membership	• Population shifts: 19-44 y/o and 45+ y/o
Pharmacy	• # Scripts Filled • % Generic dispensing • % Brand Single Source • % Non-formulary Rx • % HIV Meds @ CCHHS pharmacies • % Mail order meds @ CCHHS pharmacies
Oversight/compliance structure	• # Grievance & Appeals • # Fraud, Waste & Abuse Cases
Reinsurance	• # Claims filed

Risk Management Metrics

Key Measures	Dec'14	Target/ Comparison	% to Target/ Comparison	Notes/Comments
Risk Management				
ACA Adult Membership				
% 19-24 y/o	16.4%	17.0%	-0.6%	*Source: Payment (820) files*
% 25-34 y/o	15.2%	14.8%	0.4%	*Comparison: March'14 Actuarial Report*
% 35-44 y/o	13.2%	13.5%	-0.3%	
% 44-54 y/o	26.2%	27.6%	-1.4%	
% 55+ y/o	29.1%	27.0%	2.1%	
Pharmacy				
# Scripts filled	131,388			*Source: US Script monthly report*
% Generic dispensing	83%			*Data as of: 12/31/2014*
% Brand Single Source	16%			
% Formulary	98%	98%	0.0%	
% CCHHS HIV pt meds @ CCHHS pharmacy	23%	80%	-57.0%	
% Mail order meds @ CCHHS pharmacies	5%	20%	-14.9%	
Oversight/Compliance Structure				
# Grievances	20			*Source: Monthly HFS report filing*
# Appeals	29			
# Overturned Appeals	17			
# Fraud, Waste & Abuse Reports	5			*# Open FWA cases*
Reinsurance				*CY'14 = 1st $ transplant coverage*
# Claims filed	0			*CY'15 = $750k/incident coverage*

Care Management

Core activities to health plan operation/purpose

Critical relationships needed to manage care

Current Activities	Dashboard Metrics
PCMH assignment	Member assignment: CCHHS, MHN ACO
Referral management	# Authorizations Inpatient & Outpatient
Member risk stratification	Member Outreach HRS/HRA Completion/month YTD % High Risk members
Utilization management	Admits, Days & ER Visits per 1,000 members % Readmissions
CCHHS utilization	% ER, Hospital Inpatient, Hospital Outpatient & Primary Care Visits

Care Management Metrics

Key Measures	Dec'14	Target/ Comparison	% to Target/ Comparison	Notes/Comments
Care Management				
PCMH Assignment				
Total Membership	86,562			*Source: CountyCare data*
% Assigned CCHHS ACHN	30.4%			
% Assigned MHN ACO	28.1%			
Referral Management				
# Authorizations: Inpatient	1,041			*Source: CountyCare data*
# Authorizations: Outpatient	1,472			
Member Risk Stratification				
Total Outreached Members	25,606			*Source: CountyCare data*
Total # HRSs Completed	9,867			
Total # HRAs Completed	3,965			
YTD % High Risk Members	3.8%	2.0%	1.8%	*High Risk % of completed HRS/HRA*
Utilization Management				*Source: CountyCare data*
Admits/1,000	172			
Days/1,000	764			
ED Visits/1,000	997			
% 30-day Readmissions	21%	14.7%	6.3%	*NCQA Medicare HMOs 2013*
CCHHS Utilization				
Emergency Room	17.9%			
Hospital Inpatient	15.6%			
Hospital Outpatient	25.3%			
Primary Care	40.5%			

Operations

Day-to-day activities critical to business functions

Greatest impact on member and provider satisfaction

Current Activities	Dashboard Metrics
Call center	Call volume Abandonment rate Hold time Average speed to answer
Claims processing	# Claims processed Received-to-processed turnaround time Received-to-paid turnaround time

Operations Metrics

Key Measures	Dec'14	Target/ Comparison	% to Target/ Comparison	Notes/Comments
Operations				
Call Center			**Goal Met**	*Source: CountyCare Monthly Report*
# Calls received	22,247			
Abandonment rate	1.6%	< 4%	Y	
Hold time	:01:04	< :01:00	N	*Med mgt calls driving factor, :02:16 avg*
Average speed to answer	:00:14	< :00:45	Y	
Claims Processing			**# Days**	
# Claims processed	579,981			*Source: CountyCare Data*
Avg # Days Received-to-Processed	12	10	-2	*Service dates = 7/1/2014 through 12/31/2014*
Avg # Days Received-to-Paid	39	35	-4	

Future Initiatives

Quality of Care

- HFS Sanctions

Evidence-based practices that improve health status not traditionally covered by Medicaid (eg: housing)

Enhanced care coordination for highest-risk members (eg: children with special needs)

Expanded focus on post-corrections population